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DELAWARE STATE MEDICAL JOURNAL

Official Organ of the Medical Society of Delaware
INCORPORATED 1789

VOLUME VI
NUMBER 3

MARCH, 1934

Per Year $2.00
Per Copy 20c

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Entered as second-class matter June 28, 1929, at the Post Office at Wilmington, Delaware, under the Act of March 3, 1879. Business and Editorial offices, 1022 Du Pont Bldg., Wilmington, Delaware. Issued monthly.

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continued from last month

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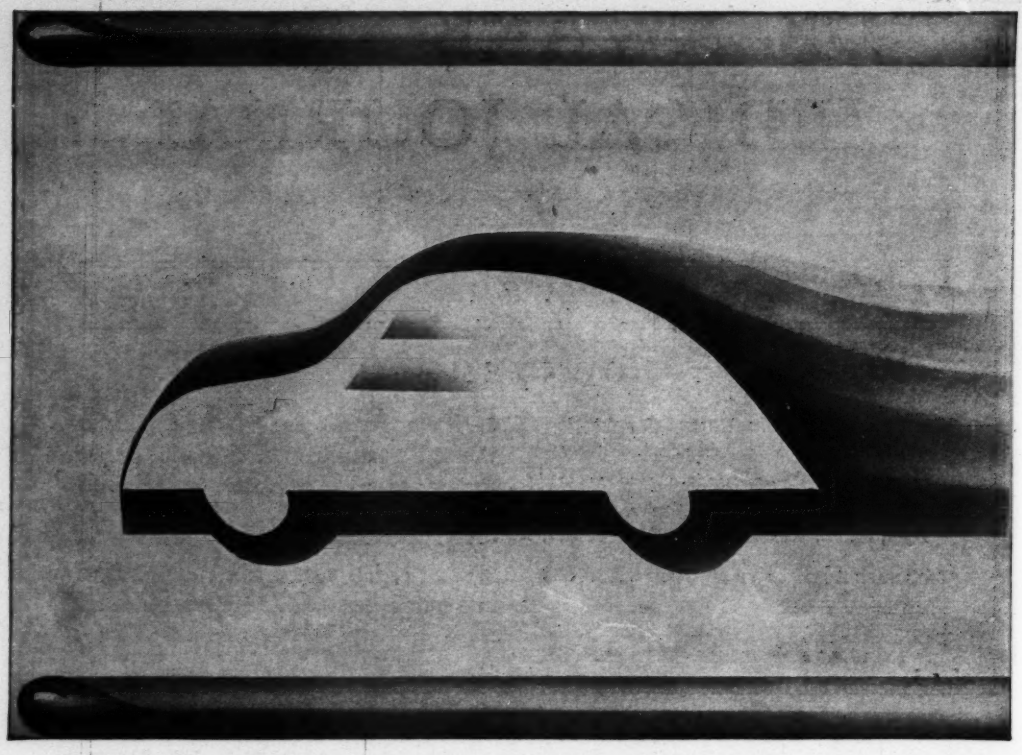

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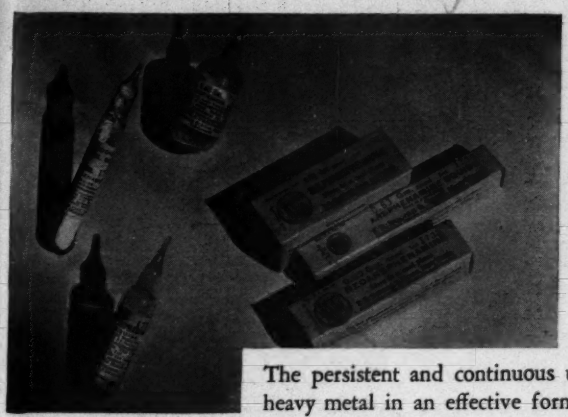

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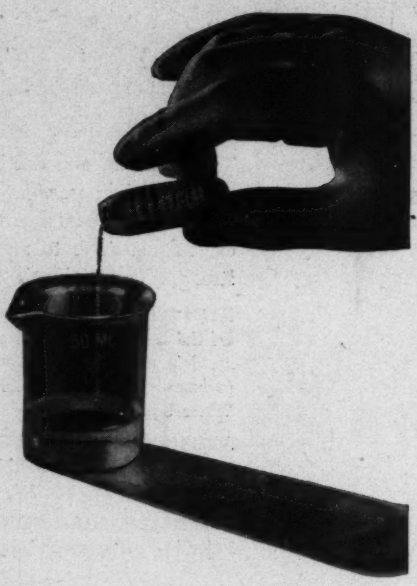

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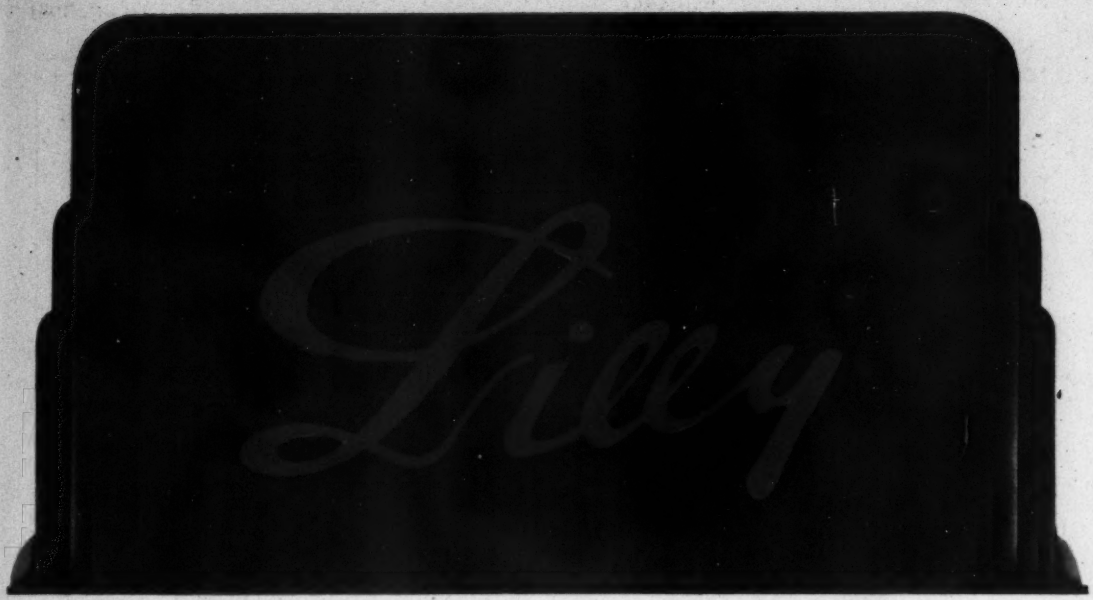

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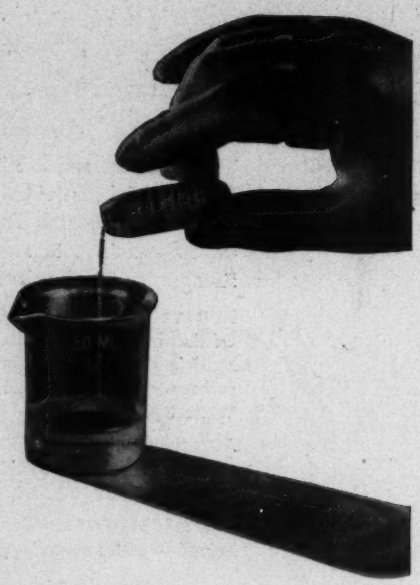

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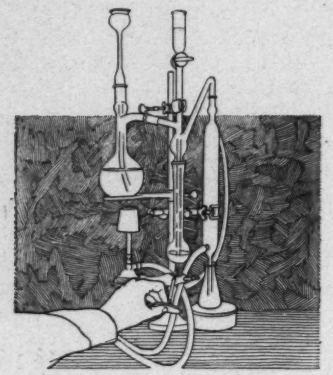

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Volume VI
Number 3

MARCH, 1934

Per Year $2.00
Per Copy 20c

CHOICE OF PHYSICIAN UNDER WORKMEN'S COMPENSATION LAWS*

LOYAL A. SHOUDY, M. D.,
Bethlehem, Penna.

The first State compensation laws became effective in 1911 (Wisconsin, Nevada, New Jersey, California, and Washington), Delaware's law became effective in 1918. Naturally, the laws of the various States differ, but with this you must agree, that all were enacted for the benefit of the *injured worker.* In forming these laws, the employer, the employee, the lawyer, all gave up something; the doctor did not, he gained something, but for the continuance of the soundness of the whole scheme he must yield, not anything he has ever possessed, but advantages he seeks to gain.

Most of the State compensation laws have been amended, some many times. As a profession you will agree that we did not pay sufficient attention to the trend of the acts. Some of us in years gone by called attention to various changes needed, but the profession as a whole displayed no great interest.

The interpretation of compensation laws, and the laws themselves have undergone many changes since first written but the "care of the injured worker" still remains as the first thought.

No doubt some of the medical problems of compensation acts would be better cared for had we physicians lent our aid earlier. We cannot discuss all these problems, and your President has asked me to present the "Choice of Physician under Workmen's Compensation Laws," and I want to start with the assumption that we are dealing with honest employees, honest employers, honest doctors, and honest insurance carriers.

The laws, as written now, place the responsibility for the care of the injured worker on the employer. The employer must provide prompt and adequate medical and surgical care for the injured worker, assuring the medical profession fair compensation for the service rendered. In cases of injury a doctor must be called; the choice of this doctor rests now with the employer. Some of you would have it that the injured man be allowed to select the doctor of his choice. The question then is: shall the employer or the injured man select the physician? Sometimes the employer is represented by his insurance carrier. Then our problems center about the choosing of the doctor.

"There are three parties at interest when an employee sustains an injury, the employee himself (and his family), the employer, and the insurance carrier; the employee because he himself suffers the injury and because he himself suffers the loss of wages through inability to work; the employer because the accident interferes with the carrying on of his industry and because he does not wantingly injure men and again the costs are his; the insurance carrier because the carrier has assumed certain of the financial responsibilities of the employer."

I admit all three have an interest. The employee, of course, has a direct interest, but my contention is that he is not in a position to make a choice. He is not in a position to judge of the qualifications of doctors. If free choice by employees were the law, you would have a virtual racket contending for the work, with "runners" and other inducements rivalling the old claims work of days gone by.

Quoting from Mr. Browne "I see no benefit that would accrue from a change in the present system. I know that in some quarters there has been a movement urging a change in the law, based on the thought that the family physician would immediately be called to the injured man when injuries oc-

*Read before the Medical Society of Delaware, Wilmington, September 26, 1933.

cur, and in that manner these cases, instead of being centralized, as they now largely are, into the hands of surgeons and practitioners making a specialty of this type of work, would be spread through the profession generally. I subscribe that such would not be the result. In the first place, there would immediately grow up groups, or organizations, with a scheme of benefits whereby all medical service would be performed by men selected by this group, the case handled in its entirety by the representatives of the group, and the high class of men now performing this serice through selection by the employer would be excluded from it. There then would be bidding for this business by the lodge insurance doctors because of the outside insurance benefits and contracts brought thereby, and the cases lifted from the physician originally selected by the employer. If you are skeptical of this, then I commend to your attention the thought that politics and other influences, of which you can conceive, would be brought to bear to send these cases to a clinic or so-called clinics, influenced by solicitors or the leading men of the nationalities to which the men belong, to have these cases centrallized in their hands. . . . Instead of coddling employers to secure this business, as now undoubtedly exists in a small way, the workman would be the object, and competition would be of the sharpest sort. Ambulance chasing in its palmiest days could not possibly be any worse than the situation that would be brought about by this change."

Political influence on the placing of this work enters now. France can furnish a good example of this at the present time.

The question presents many problems because of the various kinds of industries, the locations, and the various number of employees, as well as the hazards of the industry.

Take a plant of 5,000 men, a foundry or shipyard, and say 25 men suffer some small injury during the day and each chooses to leave the plant and go from one-half to five miles to have treatment by the doctor of his choosing. The time lost from the job is likely to hold up five or six other men on the same job. In such a plant the men have a right to ask of the employer that he comply with the law and supply adequate medical attention.

The law demands reports of all accidents, accurate accounts and check ups must be made, the injured must be followed up in treatments, and all of this requires a detail which the doctor in general practice is loath to do.

Take the problem of the construction and erection companies, bridge builders, where men are sent from State to State on jobs. Are these men in a position to know the best doctor in the community? The work is at times miles away from the nearest doctor. Is it not better if the employer learns through his medical department who is the best doctor in that community to handle such work and arrange with him to care for the injured? Arrange to have him call at the job for dressings? Arrange to send needy cases to his office or hospital? Arrange for him to designate a substitute in case he cannot be reached? These are problems which must be considered humanely and economically from the standpoint of the employee and the employer.

The care of the injured has developed within our profession a specialty—industrial physician, with men who have seen fit to devote their time and ability to this work. It has enlarged a field of surgery, call it traumatic if you choose, that heretofore did not receive the attention it should. The care for and restoration of the injured is a specialty requiring skill of the highest degree.

All doctors are not equally competent to do workmen's compensation work. "All doctors are not equally competent in general. There is a wide divergence in natural ability and in education and training, and if adequate medical attenion is to be had, account must be taken of this fact." Traumatic surgery is a specialty and the ordinary practitioner is in general not capable of rendering the highest grade of expert service in this field.

"There is a natural tendency to develop a specialized surgery in congested centers that is extremely valuable to the parties vitally interested in the compensation law, the employer and the injured man. The law which we know as the 'survival of the fittest' operates to gravitate this business to such men because it is to the employers' interest to select such men."

"In the years during which the compensation law has been operating and during which

this tendency towards specialization has slowly grown, many innocents may have suffered through unskilled service. But thanks to this development, the incompetent service is now confined to the exceptional which through ignorance or chicanery reaches the practitioner who should not have it." Are we now to cast this experience into the discard and throw away the stimulant that has built up and sustained the splendid service that is now possible for our injured men?"

The experience of one of our large insurance companies furnishes interesting figures showing the value of selected service by doctors of their choice against service by doctors selected otherwise.

Experience of the Maryland Casualty Company with Regard to Selected and Unselected Doctors

FRACTURES	Cases	Medical	Temporary Compensation	Specific Compensation	Days Disability	AVERAGES
Skull	32	$191	$127	$246	162	Selected
Skull	33	295	273	1036	602	Unselected
Vertebrae	36	330	230	740	500	Selected
Vertebrae	26	363	560	1026	866	Unselected
Ribs	8	110	70	25	31	Selected
Ribs	11	193	146	45	75	Unselected
Scapula	1	80	148	0	88	Selected
Scapula	3	44	227	0	85	Unselected
Clavicle	6	119	349	296	236	Selected
Clavicle	11	71	58	58	81	Unselected
Humerus	22	342	343	356	307	Selected
Humerus	28	316	362	711	418	Unselected
Radius	92	65	117	124	83	Selected
Radius	81	82	122	160	146	Unselected
Ulna	17	110	53	157	87	Selected
Ulna	28	110	116	74	108	Unselected
Radius & Ulna	34	155	141	205	360	Selected
Radius & Ulna	35	142	195	369	249	Unselected
Pelvis	11	183	190	0	71	Selected
Pelvis	13	336	276	273	358	Unselected
Femur	14	657	457	308	412	Selected
Femur	22	495	391	892	668	Unselected
Patella	15	195	179	42	113	Selected
Patella	8	347	361	342	267	Unselected
Tibia	74	232	256	201	271	Selected
Tibia	54	186	339	345	290	Unselected
Fibula	42	134	189	240	136	Selected
Fibula	40	89	176	98	131	Unselected
Os calcis	19	130	243	407	303	Selected
Os calcis	14	163	679	724	543	Unselected
Tibia & Fibula	7	385	328	57	232	Selected
Tibia & Fibula	18	223	321	729	525	Unselected

OTHER INJURIES	Cases	Medical	Temporary Compensation	Specific Compensation	Days Disability	AVERAGES
Lacerations	754	$25	$24	$12	16	Selected
Lacerations	338	30	24	21	20	Unselected
Contusions	692	33	30	25	18	Selected
Contusions	308	32	43	44	36	Unselected
Sprains & Strains	489	28	36	19	26	Selected
	166	58	122	48	60	Unselected
Eye Injuries	227	30	15	50	26	Selected
Eye Injuries	75	33	29	48	22	Unselected
Burns	123	33	30	33	29	Selected
Burns	51	45	55	28	34	Unselected
Traum. Amps.	44	74	50	378	200	Selected
Traum. Amps.	13	104	140	368	202	Unselected
Punctured Wds.	191	22	13	16	15	Selected
Punctured Wds.	74	49	32	84	42	Unselected
Foreign Bodies	77	22	16	5	11	Selected
Foreign Bodies	42	64	30	13	13	Unselected
Dislocations	23	38	55	131	124	Selected
Dislocations	15	118	199	20	97	Unselected
Hernias	116	135	141	0	59	Selected
Hernias	44	133	158	0	61	Unselected
Unclassified	86	90	97	40	107	Selected
Unclassified	67	32	65	151	29	Unselected

I mentioned the choice by employee, and by the employer. The third interested party is the insurance carrier. The large employer can afford to organize the situation for himself; next to this the insurance carrier is able to provide a solution "securing the best possible service becomes definitely a part of the insurance company's business." "By combining a large number of cases the carrier can afford to do whatever is necessary in order to secure the best possible service."

I am aware that in the beginning some of the carriers made the mistake of securing cheap medical service under the feeling that any doctor could do the work. They have profited by their experience and are now looking for help to supply the best doctors available. The medical departments of the carriers have convinced their companies that the best work pays. Quoting from Mr. Whitney: "The practical problem is then largely this: what steps should be taken so that insurance carriers may secure the best possible medical service; how can this service be furnished by the medical profession in the best possible way, consideration being given first to the quality of the service to be rendered and second to the conditions under which it is rendered as respects for instance, remuner-

ation and the professional status of the doctor?"

Mr. Whitney suggests a panel of doctors that desire to treat compensation cases and who are competent. The trouble is that too many doctors would desire to be on the panel, and the question comes who would name the panel? And who would revise it, or police it? I have frequently heard the argument that all doctors licensed by the State were able to practice medicine and surgery in that State and therefore were able to treat any and all compensation cases. "There must be protection against the possibility of having an injured employee fall accidentally into incompetent hands but there must also be protection against having an injured employee get into the hands of the incompetent and unscrupulous through intention and collusion. Serious abuses have grown up in the compensation field of what are medical rackets. Purging the compensation system of this evil can be accomplished only by a strict surveillance with regards to the character and competency of those who are allowed to practice in this field. If the panel system is the answer, then the insurance companies and the medical profession must get together and work out details, which you must agree will take 'expert study and collective action.' "

Free choice is not feasible because the employee is not competent to make a choice and a considerable proportion of doctors are not competent to treat compensation cases. Did you ever stop to think that we as a profession do not permit the free choice of doctors in our own organizations, the hospitals?

Most hospitals have a staff and if a man selects his own doctor he is told: "no, he's not on our staff." Or if he is admitted on Tuesday and wants DR. O. to operate he is told: "no, Tuesday is DR. X's day." We are told we have the staff to protect the people and the hospital. Only qualified and selected doctors are allowed to operate here. And so industry and carriers try to protect the employee by selecting what it considers the best doctors to care for the injured.

I favor correcting an evil, but first prove one exists. What percentage of employees are complaining of the present method? What should be done is to see that the employer fulfills his responsibility, that racket clinics be wiped out.

When you consider the compensation costs in unselected hands as against the compensation cost when these cases are handled by selected doctors (compensation 64% higher in unselected), when you consider the days lost by the injured employee (in a series of fractures alone, selected lost 1985 days, unselected lost 3139 days), when you consider the permanent disability, then I believe you will agree with me that every doctor cannot handle these cases and that free choice of physicians is not the answer.

Our own experience corresponds somewhat to that of the insurance carriers quoted. In our erection department, where the work is in various parts of the country, we try to select the doctor, surgeon, and hospital in that community best trained for this work. The end results from this work are not so satisfactory as the work accomplished in the communities where our plants are located, where the surgical work is cared for by doctors trained in this line and under our direct supervision. The days lost are less, the compensation costs are less, the permanent disability is less. The surgeon, and hospital, who handles these cases often secures much better results than the good surgeon who sees but an occasional case.

Please remember that the injured man still has the right to select his own physician, but if he does he must do as he did before the compensation laws became effective—pay for the services. He simply waives the benefits of the law.

Someone has said that it is an alienable right to choose; if such a thing as an alienable right exists, the law did not remove it.

"Medical service under workmen's compensation is

1. An obligation of the employer
2. A right of the employee

"The employer is interested economically in getting injured men back to production, thereby saving wasteful

(a) compensation payments
(b) labor turnover
(c) burdens on the community
(d) incidental expenses imposed by law

"Surely no employer is interested in either cheap or incompetent medical attention, for it is an unsound program.

"The employee is interested in being restored to economic production because while laid up he loses

(a) the waiting period
(b) the earnings in excess of compensation
(c) the expenses naturally incidental to removal from regular activities

"He wishes speedy restoration to health and strength because he suffers the pains and burdens of injury and the mental anguish which accompanies the uncertainty of such enforced idleness.

"Granting free choice would greatly increase the expense to the employer and to the State on account of additional cost of

(a) restoration
(b) exorbitant bills impossible to combat
(c) necessity of the employment of an examining physician to keep watch of cases in hands of the various doctors
(d) increased overhead caused by the employer being completely out of touch with every case, as even his physician would be barred in many instances from seeing an injured man
(e) in view of this lack of contact the present scheme of direct and prompt payments would be impossible. Distrust and suspicion would be fostered and nearly every case would be controverted
(f) throw on the Industrial Board and the machinery of the Industrial Commissioner all the burdens and evils of a bill collection agency

"The injured man would get no benefit from the change because

(a) no argument that improved treatment would result can be advanced in favor of it
(b) it would not improve the standard of the medical profession. On the contrary, it would arrest the development of the specialized service now so spledidly functioning
(c) it would not lessen but would foster quackery, and the injured men would become the subject of all sorts of absurd treatments at the expense of the employer
(d) it would offer him as the subject for uncontrollable exploitation by unscrupulous practitioners, for there would be no incentive to prompt restoration to usefulness and health."

March 25, 1928, the New York Times published a report of the Research Board of the American College of Surgeons, from which the following is an excerpt: "We approve the law as it now stands in a majority of the States, and which specifically places the control of the surgical services in the hands of the employer. We believe that industry more fully realizes the economic, financial, and humanitarian principles which apply to these problems and . . . that, in general, industry desires to provide competent aid for its injured."

Speaking on this subject, March 13, 1922, Hon. Henry D. Sayer, Industrial Commissioner of New York said:

> "The proposition that the injured workman be given the right under the supervision of the Industrial Commission to have his own physician treat him, does not meet with my approval. I do not believe that the injured workman will be better off by being given the unbridled right to go for treatment to whomever he will, subject only to the supervision of some administrative body . . . I do not believe that in this city, with its doctors drawn from every sphere and from every country, doctors who cannot even speak English, and we are to give these injured workmen the right to go to these men without any control, that will make for an improvement in the work. Until it is shown that the injured workman is suffering under the present system, or until the medical profession takes steps to rid

itself of its incompetent members who are alleged to practice medicine but are actually practicing fraud, until that is done, the injured workman ought not to have the free selection of his physician."

In the United States the injured workmen have the right to choose the physician, surgeon, etc., in only three States—Utah, Rhode Island, and Massachusetts.

In Utah the law has been so construed. The results have been far from encouraging, as is indicated by the following statement by Hon. William M. Knerr, chairman Industrial Commission of Utah, at the 1929 meeting of the International Association of Industrial Accident Boards and Commissions:

"In our State, unfortunately, we have developed what we call the ambulance-chasing doctors, who actually have runners out, men directing injured workmen to go to them, and they are not very particular in their treatment. That is an unfortunate situation, particularly in a State where we are trying so hard to preserve to the injured workman the right, the absolute right, to select his own physician; and I would like to see the day come when our medical society would take hold of this question in the right way and serve notice on all of these men who are not playing the game squarely that if they hope to be members of that society they will have to change their tactics."

In Rhode Island the injured employee has the right to select the physician and/or hospital; but in such case the employer's liability for medical and hospital charges is so strictly limited both in time and amount and so strictly conditioned upon prompt notice and reports by the physician and hospital that the employee's right is seldom insisted upon.

In Massachusetts the original law was amended to give the injured the right to choose the physician, etc., with results frequently condemned by the members of the Industrial Accident Board. Thus, for example, at the 1927 meeting of the International Association of Industrial Accident Boards and Commissions, Hon. W. W. Kennard, chairman of the Massachusetts Board, said:

"'It is an interesting thing . . . that after the experience we have had with both methods, every member of our Board, not so very long ago, went on record before the legislature in a recommendation that the insurance company should be given the right to furnish the treatment and that the employee, if he saw fit to go to his own physician, should pay his bill there for medical treatment. . . . At the present time the insurance companies, when they furnish treatment in Massachusetts, give as good as they can get."

A result of this rule in Massachusetts has been to increase the medical cost inordinately, until now it amounts approximately to half the compensation cost. For instance, in 1929, the compensation payments amounted to $6,-371,511.35 and the payments for medical benefits amounted to $3,090,450.96.

"In conclusion, it is confidently submitted that no experience can be cited contrary to the proposition that the prevailing rule as to choice of physician is the best for all concerned—employers, employees, and the medical profession. The problem is to so develop and regulate practice under that rule as to eliminate or mitigate causes of friction, hardships, and occasional abuse."

Handling compensation cases is a business, and the doctor who chooses to do this work must have the proper set-up to do the work. I am convinced that it is far the best thing to have men specialize in this work, just as they do in other branches of our profession, and when possible that men specializing in this work should not be in general practice.

The smaller industries cannot afford a full time doctor. Why not a group of industries to employ one good doctor? Why not a central clinic in a district of small industries, properly supervised or conducted, to furnish this service?

The problem industry is up against is to get proper service as and when needed. In many cases they are forced to accept the present clinics because of service, and then they must keep a close check on the work.

"Certain clinics have been organized for the treatment of compensation cases which are not only on a distinctly commercial basis, but methods have been used which are thoroughly

reprehensible, involving the splitting of fees, collusion with the employees of insurance carriers, and the faking of injuries."

My contention is that able medical and surgical clinics should be under close supervision, and should be brought to the same standards as our hospitals.

If the panel system is the answer then doctors could be selected from this panel by the insurance carrier or employer.

What the insurance carriers want to know is who are the doctors in each community best able and capable to handle this work. Those who support the panel theory are convinced that it can only be done by the medical profession and that we must set it up, maintain it and keep it up to standard, the only alternative being to have the State do it.

I have read with much interest the various reports and suggestions which have appeared of late, concerning the "medical aspects of the compensation laws," and some of them contain statements which to my way of thinking are not sound.

I can tell you for a certainty that accidents in industry have been reduced in frequency and severity. I can tell you that the individual has been considered in the accident prevention program. Of course there are all kinds of people in this world, shyster doctors as well as shyster lawyers and others, but I feel that employers and insurance carriers are human, that they are interested in the men, and that they want to supply good medical service, and I believe they are in a position to make the choice for the medical care needed. I am speaking now of the real industries; I know they want to feel confidence in the physician they select.

There are other sides to industry besides profit. The better industries and insurance carriers do not select a doctor because of the salary he will accept; they select on ability. I can say to you that the doctor in industry is encouraged by the management to do good work and given every opportunity to solve his problems. It is wrong to accuse industry of selecting doctors who will give testimony which is other than fair and just. There are bound to be differences of opinion, and I am sure industry will not ask of a physician that he give testimony contrary to his beliefs and conscience.

I know for a certainty that the better insurance carriers want to supply the best of medical skill. I know that they have asked of our profession to tell them who are the best doctors in the communities throughout the country to handle compensation work, and that they have asked us for a panel from which they could choose, and even to pay for the survey needed.

Do you not really feel that all interested parties should get together and solve these problems?

I feel that the bigger industries have solved their problems, and the medical departments of many of them have made distinct contributions to medicine.

I believe in paying full costs, medical and hospital, in these cases. But we must use care in the adjusting costs so that we are sure the insurance can be carried.

Speaking of the panel, let me in closing quote from Mr. Whitney's paper:

"I not only believe that this is the right solution of the problem in general but it is a particularly right way of solving it at the present time. We are confronted in our national life with the problem of developing a planned economy as a substitute for the haphazard way of handling our affairs which has maintained up to the present time and which has now proved to be impracticable in our complicated modern civilization. If this planned economy is not to go to either of the two extremes, Fascism on the one hand or Communism on the other, it will be only by the voluntary assumption by each industry and business and profession of the responsibility for keeping its own house in order. Working this problem out for each industry and business and profession will be the great contribution of the United States to the problem of a controlled social order. I certainly hope that the medical profession will see its way clear to understand this; you will doubtless need a certain amount of legislation, but not very much; the main thing is to feel that it is your job and that you can do it."

Conclusions

1. No argument that improved medical treatment would result from the "free choice

of physician," can be advanced in favor of it.

2. All doctors are not equally competent to do workmen's compensation work.

3. Free choice is not feasible because the greater percentage of employees are not competent to make a choice.

4. All medical clinics engaged in compensation work should be brought to as high a standard as required for our hospitals, and approved by the same organization, the American College of Surgeons.

5. Some way should be provided by the medical profession to furnish insurance carriers with a panel of the doctors capable of rendering the service needed.

6. If the panel system is accepted care must be taken to see that it is properly administered.

7. If you believe changes should be made in the present law, then let us get together with the other interested parties and work them out.

In preparing this paper I am indebted to Mr. A. W. Whitney, Mr. Tecumseh Sherman and Mr. Browne, who have given much time and thought to this subject and who have great interest in workmen's compensation at heart.

ROCKY MOUNTAIN SPOTTED FEVER*

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Rocky Mountain spotted fever is one member of a group of diseases scattered rather widely over the whole world. The three main diseases of this group, often referred to as the typhus group, are tsutsugamushi, typhus, and Rocky Mountain spotted fever. These diseases bear to each other a clinical, etiological, epidemiological and serological relationship. The three diseases that I have mentioned are separate and distinct, with no cross-immunity between them. There are other members of the group which are not well identified as yet.

Clinically these diseases are characterized by an abrupt onset—fever, prostration, some degree of mental confusion and a rash. There is an etiological suggestion of relationship from the fact that Rickettsia, are found in the tissues of animals and arthropods infected with these diseases. Epidemiologically they bear a close resemblance from the fact that they are all known to be carried either from man to man, or from some rodent or animal, to man by some blood-sucking arthropod. All produce agglutinins for some strain of Proteus X 19. This varies for some individual members of the group.

Immunologically, at least three of these diseases are distinct. Rocky Mountain spotted fever, the one we are chiefly interested in this afternoon, is known to have existed in the Rocky Mountain region since the advent of the white man as a settler in that region. Some cases with rather definite history go back as far as 1872. Maxey writing in 1898 gave us our first definite history of the disease. Wilson and Chowning in 1902 made an investigation of the disease in Montana and Idaho, and from their investigations concluded that there was a gopher reservoir of the disease existing in nature, and that the disease was transmitted from this gopher reservoir to man by the bite of the wood tick now known as the Dermacentor andersoni. In 1906 Ricketts began a study which showed the place that this wood tick played in the transmission of Rocky Mountain spotted fever. He transmitted disease by means of this tick, and also found ticks infected with Rocky Mountain spotted fever in nature.

With one or two exceptions Rocky Mountain spotted fever was thought to be restricted to about nine States in the northern Rocky Mountain area until 1930. In 1925 La Bier described a case of the disease in Indiana, and he was unable to connect this case with the original known infected area. In 1925 there was a case described in New York State in which the diagnosis of Rocky Mountain spotted fever was discarded because it had never been known to exist in this part of the country. There was a case described in the following year in Norfolk, Va., as a case of typhus transmitted by a tick bite. This case we now feel sure was spotted fever

In the summer of 1930 it was discovered that many of the cases occurring in Maryland and Virginia around the District of Columbia, and being diagnosed generally as typhus fever, were in reality Rocky Mountain spot-

*Read before the Medical Society of Delaware, Wilmington, September 27, 1933.

ted fever. We now know that practically the whole United States, with a few exceptions that I will show you on a map later, is infected or presumably infected with Rocky Mountain spotted fever. In addition to that a disease was described in 1929 in Sao Paulo, Brazil, under the name of exanthematic typhus fever. About three or four months ago we succeeded in getting a strain of virus of the Sao Paulo disease sent to us from Sao Paulo, and identified it as being a virulent strain of Rocky Mountain spotted fever. There are other diseases elsewhere over the world, as tick typhus in India, which is quite possibly Rocky Mountain spotted fever. There is a disease known as "Kenya" typhus of the province of Kenya in East Africa, which is very closely related to Rocky Mountain spotted fever, if not identical with it.

In the clinical diagnosis of Rocky Mountain spotted fever the disease with which it is most often confused is typhus, the endemic form of which is present in this country. The first point in differentiation of those two diseases is the fact that Rocky Mountain spotted fever is essentially a rural disease, while typhus is essentially an urban disease. The majority of cases of Rocky Mountain spotted fever in which a clear history can be elicited give a history of rural contact. Either their occupations expose them to areas infested with ticks, or they have been on an outing or a camping trip, or have spent the week-end out in the country.

Rocky Mountain spotted fever has an incubation period of from two to twelve days following the bite of the infected tick. Most often the incubation period is three to seven days. The last day or so of this period may show some prostration, low backache, leg pains and loss of appetite. The onset is sudden mostly with chills, repeated chills or chilly sensations, fever, prostration and headache, the appetite is lost, and constipation is the rule. Almost invariably restlessness and insomnia are present At the onset there is soreness of muscles and the joints, and the skin is sensitive to the touch. In some cases there are localized pains.

The fever comes on with the chill, and rises rapidly, each day's maximum exceeding that of the previous day. There are morning remissions which grow less as the disease progresses. The height of temperature is usually reached in the second week after the onset, usually about the tenth day. The morning remissions toward the latter part of the disease become less marked, and in some cases are practically absent. The duration of the fever is from 12 to 22 days. In most cases it is about three weeks. If recovery ensues the fever falls by rapid lysis.

The nervous and mental symptoms are often severe. Some degree of mental confusion is almost always present even in the mildest cases. This may vary from disorientation, especially on waking after a nap, or from rather wild and not easily forgotten dreams, to delirium and coma. The late manifestations, during convalescence, of nervous and mental disturbance are deafness, visual disturbances, slurring of speech, and some confusion. These may last for two or three weeks after defervescence has taken place. Convalescence may be slow but it is usually always complete.

The case fatality rate of Rocky Mountain spotted fever varies. In Idaho the case fatality rate is about 5%. In the eastern part of this country the rate varies from 22% to 25%, while in certain sections of Montana it is from 75% to 80%, and in Sao Paulo, Brazil it has been about 77%.

The rash of Rocky Mountain spotted fever is the chief point on which one must rely for clinical diagnosis. The rash comes on in Rocky Mountain spotted fever from the second to the fifth day, usually on the third or fourth day. In typhus it comes on from the fifth to the seventh day, seldom before the fifth. In Rocky Mountain spotted fever the rash first appears on the wrists and ankles. The extension is rapid to the back, the arms, the legs, the chest, and lastly to the abdomen where it is least marked. The palms and soles are commonly involved. The face is occasionally involved, and the scalp rarely. In epidemic typhus fever, the rash first appears over the lower chest and upper abdomen. The scalp is apparently never involved, in the typhus rash, and the face and palms and soles only rarely involved.

The rash of spotted fever is macular usually at the onset, or it may be maculopapular in character. It becomes fainter during the

morning fever and may disappear almost entirely. The spots can be brought out during the morning remissions of fever by the application of a tourniquet to one of the extremities. During the early part of the second week the rash becomes definitely petechial in almost all cases. Some spots become confluent, deep red and purplish. In some, along toward the later part of the disease where these spots have coalesced, we have small areas of necrosis. This is most common on the toes, lobes of the ears, fingers, etc. As defervesence occurs the rash fades and becomes brownish. It may be visible for several weeks during convalescence as brownish spots, which take on a reddish tinge, and become prominent on the application of a tourniquet or a hot bath. Desquamation takes place usually over the legs and arms where the rash has been thickest.

The laboratory diagnosis is of some aid but is not final. The differential diagnosis between Rocky Mountain spotted fever and typhus, as far as the patient is concerned, is a clinical diagnosis. Both diseases give agglutinins for Proteus X 19, in a dilution of 1:160 up to 1:10000 or even higher.

There is a neutralization test which can be performed using the patient's serum after he is convalescent. The serum may be withdrawn and mixed with Rocky Mountain spotted fever virus and injected in guinea pigs. If the patient had spotted fever there will be a definite protect in. This test is not of much value while the patient is still sick.

For the definite laboratory confirmation of the diagnosis of Rocky Mountain spotted fever in a patient, it is necessary to infect animals with blood drawn from the patient at the height of the disease. The disease may then be studied in the animals and cross-immunity tests carried out with animals infected with the strain under suspicious and known strains of Rocky Mountain spotted fever.

The prevention of Rocky Mountain spotted fever revolves around the prevention of tick bites. As you will see a little later in some of the slides, the tick is a very difficult arthropod to control over any wide areas. The best protection is personal prophylaxis. When one has gone into an area during the tick season where spotted fever is known to have existed or exists, the clothes and body should be examined at least once and preferably twice every day to remove ticks.

There is a vaccine for the treatment of Rocky Mountain spotted fever which is of value. It protects almost surely against death from a subsequent infection, and protects very well against getting the infection at all.

(Lanton demonstration)

DISCUSSION

PRESIDENT SPEER: Is there any discussion on Dr. Dyer's paper?

DR. MORRIS HARWITZ (Wilmington): I should like to ask the doctor if action can be demonstrated by sight, or merely serologically.

DR. P. W. TOMLINSON (Wilmington): When I was a boy I used to prowl about the woods a good deal, and we would get what we called seed ticks, small ticks, and sometimes in my endeavors to dislodge one the head would pull off and be buried in the skin. I never expect to go out where these ticks are which produce spotted fever, but some of those present may see fit to go, and I would like to ask Dr. Dyer what he has found to be the best method for cleaning them off the body.

I remember when I began the practice of medicine some fifty-five years ago, leeching and bleeding was practiced a good deal, and it occurred to me in treating one patient where leeches were applied, having the matter of economy in mind, while they were very busy sucking the blood, to take a pair of scissors and take off the tail end. That would keep going, and it wouldn't take so many leeches, but the minute the scissors came down on it, he pulled out. If the ticks would do that, it would be easy to take a pair of scissors and snip the tail end of the tick off, and off they would come.

DR. R. O. WARREN (Wilmington): I am very much interested in Rocky Mountain spotted fever for two reasons. In the first place I happen to be a native of Montana, and I never have seen a case very close out there, but two years ago when I was in Baltimore they did have three cases there at that time. There was an interesting thing brought out and I don't believe Dr. Dyer mentioned it.

I think one of the later laboratory tests that have been devised is taking the blood from the patient and inoculating it intratesticularly in rabbits, and that was tried in these cases we had, but nobody was very sure about the presence of the Rickettsia bodies. Dr. Shipley of the Harriett Lane Hospital, Baltimore, at this time considered the idea of inoculating over the cornea of the eye of the rabbits with cold blood from these patients, and he succeeded at that time in demonstrating the Rickettsia bodies. I believe the work he did appears in the Bulletin of Johns Hopkins Hospital for last year.

Dr. Dyer: In reply to Dr. Warren's question, I may say that the chief difficulty in the diagnosis of Rocky Mountain spotted fever lies in the differentiation of the disease from typhus fever, and Rickettsia are found in both conditions.

About pulling the ticks off, or cutting them in two. An infected tick is a dangerous sort of thing to handle. We have traced one or two cases to people who got their infection by pulling ticks off dogs and crushing them on their fingers. The best way to remove a tick is by a pair of tweezers, light tweezers with a curved end. The tick should be seized firmly by the head and pulled off by speedy action. If it is done in this way I do not think one will run any risk of leaving the tick's head in the skin.

There was one question, about the virus of Rocky Mountain spotted fever. Rickettsia have been described for Rocky Mountain spotted fever. They have been shown in the tissues of animals and tissues of arthropods. The same thing is true of typhus and the rest of this group of diseases. These Rickettsia are almost constantly present in infected ticks, but bodies which cannot microscopically be told from Rickettsia may be found in normal ticks.

I think the preponderance of evidence is that these Rickettsia are some phase at least of the etiological agent of spotted fever and the other members of these typhus-like diseases.

DELAWARE ACADEMY OF MEDICINE

Library Notes

The literature of medicine and dentistry has grown to such vast proportions that it must of necessity be shared in common. In developing our collection, which has as its nucleus approximately two thousand volumes on medicine, dentistry, surgery and allied subjects, we are mindful that a library is intended for the joint use of individuals, and that its facilities should afford as wide a range of reading and investigation as possible.

With the results of the world's greatest teachers, clinics, and laboratories within reach of his fingertips in a library, it is within the power of everyone to keep pace with the present. The investigator turns to the library to compare his results with those of others, and for this he must have the records of past generations as well as those of yesterday. We read of Osler at twenty-six traveling from Toronto to Boston to look up "a small matter" which he wished to "make as complete as possible."

"The best thing that can be done with a library is to use it," quoting from James P. Warbasse, M. D. "The best place for a medical library is in the midst of medical practice, where things are being done. The doctor who knows and uses his literature gets along best. The medical library, the repository of the wisdom of all time, serves the individual doctor to broaden the understanding of his problems, to raise himself to a vantage point from which more can be seen, and to give him added joys and satisfaction in his profession."

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Richmond; Garrett & Massie, 449p.

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Phil; Saunders, 1929, 996p.

Robinson, V. The story of medicine.
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Kolmer, J. A. Infection, immunity and biologic therapy. 3 ed.
Phil; Saunders, 1923, 1210p.

Stitt, E. R. Diagnosis and treatment of tropical diseases. 5 ed.
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Jones, (Sir) R. and Lovett, R. W. Orthopedic surgery. 2 ed.
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Kanavel, A. B. Infections of the hand. 6 ed.
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Speed, K. Fractures and dislocations. 2 ed.
Phil; Lea, 1928, 952p.

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Ewing, J. Neoplastic diseases. 3 ed.
Phil; Saunders, 1928, 1127p.

MacCallum, W. G. Text-book of pathology. 5 ed.
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Geschickter, C. F. and Copeland, M. M. Tumors of the bone.
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Marriott, W. M. Infant nutrition.
St. Louis, Mosby, 1930, 375p.

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Kovacs, R. Electrotherapy and the elements of light therapy.
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Starling, E. H. Principles of human physiology. 6 ed.
Phil; Lea, 1933, 1122p.

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Hare, H. A. Text-book of practical therapeutics. 21 ed.
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Keyes, E. L. Urology. 10 ed.
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CANCER COMMENT

Status of the Present Treatment of Carcinoma of the Cervix Uteri

MARION Z. H. FREEMAN*
Wilmington, Del.

Prior to the last decade of the nineteenth century, the results of surgical treatment of cancer of the cervix were very poor. In 1895 the work of Wertheim, Clark, Ries, and Rumpf, describing various improvements and new ideas, appeared. Even in the hands of these skilled men the operative mortality ranged from 8 to 26% in groups of cases considered operable.

With the discovery of the x-ray and radium a new method of treatment became available, in which the operative mortality is negligible, in spite of the fact that a general anesthetic is frequently used during the administration of the radium.

*Secretary-technician of the Delaware Junior Clinics.

In the beginning the results were variable and distressing, prohibiting any conclusion as to the comparable efficiency of these forms of treatment, but as more was learned of the physical properties of radium and x-ray rapid strides were made in the perfection of the treatment and a decided improvement was noted in the reports of five-year cures.

Dr. W. P. Healey, (N. Y. St. Jour. Med., Jan. 1, 1934) outlines the following procedure of treatment used at the Memorial Hospital, New York, with favorable results:

Cases are divided into three clinical groups, combining Schmitz's groups one and two into the first, which he calls early or favorable. This group is composed of patients in which the lesion is confined to the cervix. Group two includes patients in which the fundus or parametrium or both are involved moderately, and is called advanced or unfavorable. Group three are patients in which there is widespread invasion or metastasis. This group is designated as pallitive, and treated accordingly.

In a group of 1574 cases mentioned by Dr. Healey, 97.3% were of the squamous cell type and the remaining 2.7% glandular or adenocarcinoma. Histologically, the degree of radio sensitivity varies with the degree of malignancy. The tumors are divided into four grades, the first being composed of the most mature and least radio sensitive cells, and the fourth of the most embryonal or anaplastic type, which is most radio sensitive. With the clinical groups and pathological grades known the choice of treatment and the prognosis can be estimated with a considerable degree of scientific accuracy. Many clinics have definite plans for treatment of radium and x-ray varying with the equipment available and the personal opinion of the operator.

Dr. Healey advises a four-step plan of treatment as follows: (A) A high voltage cycle of 4 treatments of 700 Roentgen units, each two anterior and two posterior, given with a 200 K. V. machine; (B) ten to fourteen days later radium is applied to the vaginal surface of the lesion by means of vaginal applicators, for 1000 to 2000 milligram hours; (C) The following day, under anesthesia, two radium capsules in tandem formation are placed in the cervical and supra-cervical canals for 2000 and 1000 milligram hours respectively; (D) Eight weeks following the first x-ray cycle a second similar x-ray cycle is given; after which, in four to six weeks, in practically every instance the response will be found to be satisfactory. It is the cancer that has invaded other pelvic structures distant from the cervix which will terminate the life of the patient unless it can be controlled. This method of treatment which is called "cross-fire radiation method" is planned to destroy not only the growth on the cervix but any extension or metastases into the parametrium. Dr. Healey considers it doubtful that enough radiation can be obtained two inches from the radium applicators to control cancer at or beyond that point. Interstitial radiation with radium needles or radon seeds is not used as a part of the routine of the Memorial Hospital but may be used as a later treatment for any portion of the lesion that fails to regress completely, but this is not often necessary.

An important step in the treatment of patients who have received this method of treatment is the post-radiation follow-up. They should be observed at monthly intervals for the first six months, then every three months for the first year, after which six-month intervals suffice, but this follow-up should be continued for two or three years.

The essential conclusion is that the treatment of cancer of the cervix should be irradiation exclusively, the primary operative mortality in surgical therapy being one consideration.

That early diagnosis and treatment is an important factor in the establishing of a favorable prognosis goes without saying. The Schiller method of diagnosis (Surg. Arm. & Obstet., Book 50, 2, 1933), has proven an important aid in the diagnosis of early lesions. Dr. Healey feels that earlier diagnosis seems out of the question until women who have borne children can be induced to resort to periodic pelvic examinations at intervals of nine to twelve months in order that suspicious changes may be detected and checked up by biopsy if necessary.

WOMAN'S AUXILIARY ASSOCIATION

Mrs. James Blake, *President*,
Hopkins, Minnesota
Mrs. Robert W. Tomlinson, *President-Elect*,
Wilmington, Delaware
Mrs. Robert E. Fitzgerald
Chairman, Press and Publicity

The Nobel Prize in Medicine has been awarded to Dr. Thomas Hunt Morgan of Pasadena. Dr. Morgan is director of the William G. Kerckhoff biological laboratories of the California Institute of Technology. Dr. Robert A. Millikan, himself a winner of the Nobel Prize, gives the following estimate of Dr. Morgan's researches:

"The discoveries that are grouped around the idea of chromosomes and genes—discoveries that enable us to connect hereditary qualities with actual minute objects observable in microscopes—represent probably as fundamental an advance in biology as has ever been made in history. It is altogether comparable with the discovery of the circulation of the blood by Harvey or the germ theory of disease by Pasteur. This discovery and the whole group of developments that have been associated with it have been made by a group of Americans, of which Thomas Hunt Morgan has been universally recognized leader for the past twenty years."

The reports which come in from the various States each month are most interesting and inspiring, but—there are not enough of them. Many States have sent in no reports since last June and we are anxious to know what they are doing. As has been said before, the interchange of ideas is the source of greater inspiration to activity than any other one thing. By learning what is being done elsewhere, by carefully selecting what is best adapted to our needs and by adding whatever new ideas we may have, we may arrive at a course of action admirably suited to our needs. Our responsibility does not stop here—we should in turn pass on to others what we are doing. I urge every State chairman of press and publicity to do her share. Write and tell me what your State is doing—won't you?

As we promised you in the last News Letter we shall send you each month a short list of some of the articles appearing in State journals throughout the country which may be of interest to you. We have been careful to include no scientific articles in this list. Self-education for an auxiliary member does not mean a delving into the study of the science of medicine, on the other hand we should aim to be conversant with those aspects of our husbands' profession which are discussed most by the layman because in the approach to the layman many more ways are open to us than to the doctors themselves.

READING LIST

The Movies and Health—Editorial, Virginia Medical Monthly, January, 1934.

The Healing Gods or Medical Superstition—By Joseph L. Miller, M. D., West Virginia Medical Journal, November, 1933.

Some Trends in Medical Economics—By R. G. Leland, M. D., West Virginia Medical Journal, December, 1933.

Shall I Study Medicine?—Editorial, Minnesota Medicine, November, 1933.

Federal Food and Drugs Act—U. S. Senate Bill 1944 (Copeland)—Editorial, California and Western Medicine, January, 1934.

MISCELLANEOUS

State Board of Health

Diphtheria Immunization in Wilmington, 1934

The New Castle County Medical Society at the meeting on Tuesday evening, February 20th, accepted the State Board of Health plan whereby the practicing physicians of Wilmington will be given the opportunity of conducting the diphtheria prevention work in the city.

Plans are now being made to begin the treatments the week of March 5th, 1934. If you care to participate in the campaign, will you kindly signify on the enclosed postal card the days and hours when it will be convenient for you to administer the treatments. If the card is not received from you, it will be understood that you do not care to participate.

Briefly the plan is as follows:

The alum precipitated diphtheria toxoid will be supplied without cost to the physicians.

The State Board of Health will supervise the work of field nurses who will visit the homes of pre-school and school children and obtain the request for the treatments from the parents and direct the children to the offices of the physicians selected by the parents.

The fees agreed upon by the Medical Society are one dollar for those who can afford to pay, the usual fee for those on relief (if satisfactory arrangements can be made with the Relief Commission*) and for those who are not on relief but who cannot afford to pay there is no charge. The physician is to determine into which class each belongs. The State Board of Health will not be held responsible for the payment of any of these fees.

All diphtheria prevention clinics operated in the city by the State Board of Health have been discontinued.

There are approximately 15,000 children under nine years of age in the city who have not received the preventive treatments.

As soon as the enclosed card is received from you, the nurses will be prepared to send the cases to your office.

For the purpose of procuring protective treatment for every child in Wilmington, the city is being divided into districts as follows:

District No. 1—On the east by Market Street, on the north by Brandywine Creek, on the west by Franklin Street and on the south by Front Street and Lancaster Avenue.

District No. 2—On the east by Franklin Street, on the north by Delaware Avenue and 19th Street, on the west by City Line, on the south by 4th Street.

District No. 3—On the east by Franklin Street, on the north by Brandywine Creek and the City Line, the west by City Line and on the south by Delaware Avenue and 19th Street.

District No. 4—That portion of the city south of Lancaster Avenue and Front and Franklin Streets and south of Fourth Street from Franklin to Dupont and east of Dupont.

District No. 5—That portion of the city south of Fourth Street and west of Dupont.

District No. 6—That portion of the city south of the Christiana across Third Street Bridge.

District No. 7—That portion of the city south of Brandywine Creek and east of Market Street to Third Street Bridge.

District No. 8—That portion of the city north of Brandywine Creek and east of Market Street.

District No. 9—That portion of the city north of Brandywine Creek and west of Market Street.

*Ed. Note—The Relief Commission has no funds that can be applied to prophylactic treatments.

WHOLE BLOOD

In the treatment of Measles

(Taken from Schamberg & Kolmer)

"The technique may be any one of several simple procedures as follows:—

1. According as 20 or 40 cc. of blood are required, one or two 25-cc. Record syringes are sterilized, 2 cc. of 5 per cent solution of citrate placed in each, the syringe or syringes filled with blood from the donor, the contents mixed and the injection given intramuscularly into the thighs or buttocks.

2. Or the required amount of citrate solution (2 cc. of a 5 per cent. solution for each 20 to 25 cc. of blood) is placed in a sterile bottle, blood aspirated from a vein of the donor and expelled into the bottle. As a general rule, only one syringe is required, as it may be easily filled twice without washing between fillings, a finger closing the end of the needle to prevent bleeding while the syringe is being emptied. After the blood is secured the tourniquet is released, the syringe washed out once or twice with saline solution and the injection given.

3. Or one, two or more syringefuls of blood may be collected and expelled into a sterile bottle or flask containing glass beads, shaken for a few minutes for defibrination and the blood injected intramuscularly.

4. Or, if the patient is placed close at hand, and only 20 to 25 cc. of blood are required, a syringeful may be collected, using a gauge No. 16 or 18 needle to facilitate quick filling, the tournique released, needle and syringe withdrawn, and the blood injected at once (but not too rapidly) before it has had time to coagulate in the syringe."

The amount usually given as a dose is 20 cc.

EDITORIAL

DELAWARE STATE MEDICAL JOURNAL

Owned and published by the Medical Society of Delaware. Issued about the twentieth of each month under the supervision of the Publication Committee.

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Articles sent this Journal for publication and all those read at the annual meetings of the State Society are the sole property of this Journal. The Journal relies on each individual contributor's strict adherence to this well-known rule of medical journalism. In the event an article sent this Journal for publication is published before appearance in the Journal, the manuscript will be returned to the writer.

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Reprints of original articles will be supplied at actual cost, provided request for them is attached to manuscripts or made in sufficient time before publication.

All correspondence regarding editorial matters, articles, book reviews, etc., should be addressed to the Editor. All correspondence regarding advertisements, rates, etc., should be addressed to the Business Manager.

Local news of possible interest to the medical profession, notes on removals, changes in address, births, deaths and weddings will be gratefully received.

All advertisements are received subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association.

It is suggested that wherever possible members of the State Society should patronize our advertisers in preference to others as a matter of fair reciprocity.

Subscription price: $2.00 per annum in advance. Single copies, 20 cents. Foreign countries: $2.50 per annum.

VOL. VI MARCH, 1934 No. 3

RE: F. E. R. A.

The agreement entered into between the Medical Society of Delaware and the Emergency Relief Commission, fully reported in THE JOURNAL for December, 1933, is now three months old. Like all such propositions that are both new and large, there has been some lost motion, some misunderstanding, and perhaps some injustice, but taken in the by and large, we know, on the one hand, that the majority of the profession expresses satisfaction with the present arrangement, and on the other hand, the Commission is well satisfied that the most of the medical men are playing ball properly.

To those who complain at the delay in getting their pay checks we wish to say that it takes about thirty days for the bills to pass through the commission's offices. Bills can be materially expedited if the following instructions, as outlined by the Accounting Department, are followed:

"Our audit of January bills for medical services to our clients reveal that many doctors are not following the regulations as agreed upon by your committee with the Relief Commission and published in your December proceedings."

"Our complaint falls into four classifications: (1) Only one copy of bill submitted. (2) A bill for each client submitted instead of one bill listing all clients attended during the calendar month. (3) No diagnosis is given and calls are not itemized by dates and kind of call. (4) Bill submitted before case is dismissed."

"We therefore again ask that your committee call to the attention of all doctors the following:"

(1) Send 3 copies (instead of 2) of bill to Accounting Department, Emergency Relief Commission, Room M-213 Delaware Trust Building.

(2) Send only one bill, covering only those cases completed during the previous calendar month.

(3) List on bill name of client attended, address and total charged for case.

(4) Attach to bill, white authorization form, listing on back date of each visit, charge for medication, mileage, etc., and diagnosis.

"You will note that we now request the bill be made in triplicate instead of duplicate. The additional copy is necessary for our records."

Please disseminate this letter so that bills submitted March 1st for February services will conform. It would also help us expedite the work of auditing if doctors presented their bills promptly. Authorization was issued in January to 69 doctors. To date only 29 have submitted their bill.

A few complaints concerning the free choice of physician have been made, but, when fully investigated, they have usually been found to be due to some misunderstanding on the part of the patient. Likewise, any

delay in receiving the written authorization within 48 hours of the initial request can be promptly terminated by a telephone call to the Commission.

The only points now that need clarification are: (1) The tendency of certain physicians to accumulate cases over the week-end, when the Commission offices are closed; and (2) The establishment of a proper schedule of fees for special services such as surgery, x-ray, cardiology, etc. Both these problems are under consideration by the Commission and the Committee on Medical Economics, and we have no doubt that a mutually satisfactory understanding will be reached.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Co-operative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Co-operative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages, but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Co-operative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

When you come to the end of a perfect day, night begins, and then — another day. For five years THE JOURNAL has been printed by Cann Brothers and Kindig, who have rendered exceptional service. These good folks have, corporately speaking, passed to the great beyond, and we of THE JOURNAL mourn for the loss of tried and true friends. For five years, a perfect day; for three months, night.

And then — another day, whose dawning finds us back again with even older friends, The Star Publishing Company, who were the printers of THE JOURNAL from 1916 to 1923, inclusive. We have no doubts as to achieving success, so far as the printing and such matters is concerned; we know, from past experience, the courtesy, consideration and efficiency that awaits us. And so — good luck, Star!

We are trying to keep our directory page up-to-date. If the secretaries of the various societies listed there will notify us as soon as any changes are made in their lists proper corrections in THE JOURNAL will be made at once. Thank you.

When a man has successfully carried the load for fifteen years, and left behind him, locally and nationally, a record that will be hard for a Delawarean to surpass, should not some public recognition be made of it? How about giving Ex-Secretary La Motte a testimonial dinner?

PROPAGANDA FOR REFORM

HEMP MASSAGER NOT ACCEPTABLE.—The Council on Physical Therapy reports that the Hemp Massager, manufactured by the Conley Company, Inc., Rochester, Minn., consists of two rubber balls mounted on spindles at right angles to each other. As this device is pulled along over the body, the rubber balls pinch the skin and by friction lift it and underlying superficial tissues above the contour of the body or limbs. The Council investigated this massager and declared that it did exactly what, in practicing good massage, a masseur tries to avoid; it pinches the superficial tissues instead of picking up and kneading deep tissues as well as the superficial. Even if the massager faithfully duplicated hand massage there are certain statements in the advertising for which critical evidence is not available. The Council objected to the claims made for the relief of headache, nervousness and constipation. In reality, these conditions might be caused by some impaired function other than that for which massage is justly indicated. The Council regards the advertising as objectionable, because satisfactory evidence is not in its possession to substantiate the efficacy of massage with this unit in the conditions mentioned. It has declared the Hemp Massager ineligible for inclusion in its list of accepted devices. (Jour. A. M. A., February 10, 1934, p. 455.)

NUTRO NOT ACCEPTABLE.—The Committee on Foods reports that the Nutravena Company, Battle Creek, Mich., submitted a cooked mixture of roasted peanuts, wheat gluten, and sodium chloride (proportions not known)

called "Nutro. A Highly Nourishing Nut and Grain Food." The advertising unjustifiably ascribes special health values to this ordinary peanut and wheat gluten mixture and falsely alleges that it is more nourishing and "healthier" than meat and that meat is harmful, producing "pimples or facial blemishes," containing "poisonous bacteria...uric acid ...and ptomaine poison." It is incorrectly described as containing "choice nut meats and full cereal grains." The product is not "rich in vitamines" (implying all the vitamins) or "all body-building essentials." The company advised in a general way that new advertising would conform to requirements of the Committee and that it is not its "desire to put misleading advertising out to take advantage of the gullible and uninformed." The new label for the product, however, carries the claims given above. No descriptive statement identifying the ingredients of the product accompanies the trade name. The company has ignored requests that it demonstrate that its present advertising complies with the requirements of the Committee. This product will therefore not be listed among the Committee's accepted foods. (Jour. A. M. A., February 10, 1934, p. 456.)

BALDINGER'S RAZAVA BREAD.—The Committee on Foods reports that H. Baldinger and Company, St. Paul, submitted a bread called Baldinger's Razava Bread, prepared from rye bran, shortening, salt and water without the use of any special leavening agent. The advertising states or implies that this bread is a specific cure for diabetes, indigestion and dyspepsia. The advertising represents an attempt to exploit the diabetic or the dyspeptic patient by misinforming him of the true values of the bread or the proper treatment of these pathologic conditions. It promotes self-diagnosis and self-treatment by the sick who should be under the care of the physician. Advertising is incapable of prescribing the diet or treatment of the sick. The manufacturer was advised of the Committee's report but has ignored its recommendations and criticisms for correcting the advertising and labels. This product will therefore not be listed among the Committee's accepted foods. (Jour. A. M. A., February 17, 1934, p. 538.)

ALPHA-DINITROPHENOL — A METABOLIC STIMULANT.—A year has elapsed since alpha-dinitrophenol was introduced into therapeutics as a metabolic stimulant by Tainter and his collaborators of the Stanford University. Considering the potency of the drug, few untoward results or accidents have been reported. The only definite side-action from the therapeutic use of the drug is a skin rash, which occurs in about one out of every fifteen cases. The rash is uncomfortable for a few days and then disappears without sequelae. There have been no deleterious effects observed so far on the kidneys, but rather the contrary. Likewise the liver appears not to be damaged. The introduction of dinitrophenol into therapeutics has aroused widespread interest in metabolic stimulants in general, and in substitutes for this drug, in particular. Already certain British workers are proceeding to test the therapeutic actions of a related cresol. No information is at hand on the frequency of undesirable effects from this cresol, nor is its clinical toxicity or efficiency established. Therefore the dinitrocresol is still in the experimental stage and not ready for general therapeutic use. In contrast, the past year's experience with dinitrophenol has shown it apparently to be a relatively safe and reliable metabolic stimulant with which the practitioner may obtain therapeutic results. This does not mean that dinitrophenol should be given to every obese patient. In those cases in which diet has failed and thyroil is either not needed or not tolerated, dinitrophenol may be used with good prospects of benefit. However, this agent must be used only under carefully controlled conditions and with due regard for the possibility that more extensive use may bring to light as yet unsuspected toxic effect. (Jour. A. M. A., February 17, 1934, p. 542.)

UROTEX.—According to the formula on the label, Urotex consists of two tablets, A and B. Tablet A (gray) contains hexamethylenamine, ext. nux vomica, acid benzoic, and atropine sulphate. Tablet B (brown) contains ext. buchu, ext. corn silk, ext. triticum, pot. bicarbonate, sodium borate, caffeine and atropine sulphate. These formulas represent the shotgun type of proprietary sold to physicians in the period preceding 1906, except that the composition appears on the label

The product has not been submitted to the Council on Pharmacy and Chemistry for consideration. It goes without saying, however, that the Council would not approve such a product. (Jour. A. M. A., February 17, 1934, p. 561.)

OCTOZONE NOT ACCEPTABLE FOR N. N. R.—The Council of Pharmacy and Chemistry reports that the Octozone Corporation of America presented a labile gaseous preparation called "Octozone" and the apparatus ("Electroniseur") for preparing this gas from oxygen by the action of an electrical discharge. The product is proposed for the treatment of a large variety of diseases, in particular various forms of arthritis, by local application, by baths in closed bags, by subcutaneous or intramuscular injection, by rectal administration or by mouth dissolved in water. As the evidence seems to be fairly conclusive that "Octozone" is a mixture of O_2 and O_3, the Council decided that no proprietary name for the gas could be recognized, since ozone is not a new discovery, either from a chemical or from a therapeutic standpoint. The Council found the evidence of therapeutic usefulness submitted by the firm unconvincing. It appears that, under the impression that the gas was a new preparation, investigators have used it on patients without preliminary work on animals; at least such work was not reported in the available data. Among the various conditions treated with Octozone are furunculosis, varicose ulcer, fibrositis, ulcerative colitis, sciatica, "rheumatism," subphrenic abscess, osteomyelitis, hemorrhoids, and Oxyuris vermicularis infestation. The use of ozone in the treatment of wounds is not new, and according to some investigators it has a field of therapeutic usefulness, although this is very limited. It appears that the intelligent employment of ozone may yet find for it a therapeutic niche. But such use as it has so far received under the name "Octozone," cannot but further discredit the employment of this oxidizing agent in the treatment of disease. The Council declared Octozone unacceptable for New and Nonofficial Remedies because, according to the available evidence, it is the well known ozone marketed under a proprietary name with extravagant, unwarranted and even dangerous therapeutic claims. (Jour. A. M. A., February 24, 1934, p. 605.)

FELSOL.—According to a brochure entitled "Contribution to the Therapy of Bronchial Asthma," by Dr. M. Kaercher, the composition of Felsol is now given as: Metozin 0.9 (Phenazone 0.25, Anilipyrine 0.4, Iodpyrin 0.25), Caffeine 0.1, digitalis and strophanthus glucosides 0.0015, and the alkaloid iobelia inflata 0.005 Gm. Tests made some time ago in the A. M. A. Chemical Laboratory indicated that the product contained an acetanilid derivative in addition to other products. The substance may be looked on as a shotgun type of mixture promoted in typical "patent medicine" style. (Jour. A. M. A., February 24 1934, p. 640.)

Pain and Tenderness of Abdominal Wall

According to JOHN BERTON CARNETT, Philadelphia (*Journal A. M. A.*, Feb. 3, 1934), pain and tenderness occur far more frequently in the abdominal wall than in the abdominal viscera. Palpation over relaxed abdominal muscles fails completely to differentiate parietal from visceral tenderness. Parietal tenderness and, inferentially, pain are demonstrated best by making firm palpation while the patient balloons out the abdomen and holds the abdominal muscles as tense as possible. Hypersensitiveness, either on pricking or stroking the abdominal skin with a pin, or on pinching a liberal fold of skin and fat, indicates parietal tenderness. Pain and tenderness of the abdominal parietes are variously interpreted by different diagnosticians. The majority fail to consider the possibility of these two symptoms being located in the abdominal wall, neglect to apply the special tests to determine their parietal location, and wrongly ascribe them to an existent or non-existent lesion of an underlying viscus. Many times when the pain and tenderness are not recognized as parietal they are attributed to malingering, hysteria or some other vague neurosis, because they are atypical of organic visceral disease or the latter has been excluded by extensive clinical and laboratory studies, often including one or more futile laparotomies. The four areas of distribution of the first lumbar nerve afford

many points of interest in the study of parietal pain and tenderness. Libman's classification of patients into sensitive and hyposensitive in accordance with his studies at the mastoid tip and styloid process is not applicable to cases of pain and tenderness of the abdominal parietes. The only parietal pain and tenderness of fairly consistent type in location, size and frequency of association with a visceral lesion of which the author is aware is an area the size of a thumb nail situated in the midline about midway between the umbilicus and the tip of the xiphoid process, in ulcer of the stomach or duodenum. It is his belief that the shoulder or scapular reference of pain and tenderness in biliary colic occurs only as an aggravation of a neuralgia, primarily due to some extraneous cause, and that the neuralgia is not cured by complete removal of the biliary pathologic changes. Parietal pain and tenderness of the abdomen are usually due to a neuralgia and, as a rule, are independent of any intra-abdominal lesion. Failure to recognize neuralgia by the pinch test of skin and fat leads to many erroneous diagnoses. Pain and tenderness may not always be due to the same mechanism, a fact which seems to have escaped many clinicians. Chronic parietal pain and tenderness that have been present for months or years are not due to and are not cured by the operative removal of intra-abdominal lesions. Chronic parietal tenderness in the absence of spontaneous pain is a not infrequent observation in routine physical examinations in patients with spinal lesions causing mild neuralgia. Chronic neuralgia may start in the chronic form but more commonly it is preceded by recurrent acute attacks which are frequently mistaken for acute visceral disease. Acute parietal pain and tenderness are usually due to acute infections that do not require operation and disappear rapidly on subsidence of the toxema resulting from the infections. Acute pain and tenderness of the abdominal wall, and not infrequently elsewhere on the body surface, are caused by acute appendicitis infrequently, by acute pelvic inflammatory disease fairly commonly and by other intra-abdominal infections rather rarely. Acute toxemia is responsible for the great majority of the cases in which acute intra-abdominal infections cause acute parietal pain and tenderness, especially when the affected parietal area lies entirely outside the Head zone for the particular visceral lesion present. Most commonly, acute pain and tenderness of the abdominal wall are not associated with an acute intra-abdominal lesion, and on the other hand acute visceral lesions commonly do not cause parietal pain and tenderness. Acute neuralgia calls for treatment of the causative acute infection or spinal injury. Scoliosis is treated by appropriate exercises and by elevation of the heel of the shoe if a short leg is found. Parietal pain and tenderness due to spinal arthritis are promptly relieved in the majority of cases by mild irradiation of that portion of the spine from which the affected nerves emerge. Treatment of excessive lumbar lordosis by the Goldthwait special exercises to correct bad body mechanics cures parietal pain and benefits digestive disturbances, although the tenderness may be slow in disappearing.

Observations on Individual Sensitiveness to Pain, with Especial Reference to Abdominal Disorders

Emanuel Libman, New York (*Journal A. M. A.*, Feb. 3, 1934), discusses individual sensitiveness to pain, substitution symptoms and radiations of pain. Some other important subjects, such as sensitiveness of diseased blood vessels and pains due to them, can only be touched on. Besides summarizing his earlier publications, he gives a survey of recent investigations. Theoretical questions are not discussed. Many methods of gauging sensitiveness to pain have been suggested. The simple test that he employs is carried out by first pressing the thumb against the tip of the mastoid bone and then slipping the finger forward and pushing against the styloid process. Pressure on the normal mastoid bone causes no pain and therefore serves as a control. It is important not to rub the bone, because rubbing the periosteum of any bone is apt to evoke pain. Pressure in the direction of the styloid process is painful to some persons and not to others. The sensitive point is really not the styloid process but a branch of the auricularis magnus nerve. Algesimeters do not appear to be of service in practical clinical tests.

Clinical Aspects of Abdominal Pain

F. M. POTTENGER, Monrovia, Calif. (*Journal A. M. A.*, Feb. 3, 1934), states that exaggeration of a sensory stimulus, whether it is transmitted centrad over cranial or spinal afferent nerves from the skeletal structures or over the afferent systems that accompany the sympathetics and parasympathetics to the internal viscera, may lead to discomfort or pain. Pain is the automatic danger signal that tells the individual to beware, for the normal mechanism is irritated in an abnormal manner, or even its integrity may be threatened. In considering pain, it is necessary for the clinician to remember that the perception of painful stimuli is bound up with the patient's physiologic stability and that the complaint of sensory changes will differ greatly in different individuals. What may be a painful stimulus to one person may not be to another. The author discusses the following phases of pain as they pertain to abdominal pain; the visceral nervous system, the nature of visceral pain, the segmental nature of visceral pain, the difficulty of comprehending reflex effects, the difference in acute and chronic pain and the usual location of pain for the principal abdominal viscera.

Sarcoma of Cheek Following Tricho X-Ray Treatment for Hair on Face

IRA I. KAPLAN, New York (*Journal A. M. A.*, Feb. 24, 1934), points out that repeated roentgen treatments may cause destructive lesions of the skin. Because of its potential danger, irradiation should be employed only by those properly qualified by special training and experience. These destructive changes may occur many months or even years after treatment. Malignant changes may occur following necrosis in an over-irradiated skin area. The removal of hair by x-rays is fraught with danger. The author reports a case in which sarcomatous degeneration followed repeated treatments with x-rays for hair on the face, applied by Tricho, a commercial beauty parlor.

BOOK REVIEW

San Francisco Cancer Survey—Eighth Preliminary Report. By Frederick L. Hoffman, LL. D., Consulting Statistician, Prudential Insurance Company, Pp. 314. Paper. Newark: Prudential Press, 1933.

The bulk of this survey makes available a vast amount of detailed information regarding cancer statistics, since it is based upon an analysis of about 62,000 cancer death certificates from a number of important localities in this country and abroad. The material is classified with regard to such items as average age, average known duration of the disease, distribution of cancer by organs and parts, percentage of deaths preceded by operation, autopsies, etc. Forty pages of the report are devoted to a discussion of cancer in relation to diet and nutrition, a topic which the author considers to be one of the most important aspects of the whole problem. It is a distinct surprise to pass from a painstaking analysis of cancer mortality records to a highly speculative discourse on cancer in relation to diet and nutrition in which the author concludes that the chief and underlying causative factors in cancer are probably to be found in dietary disorders inherent in a highly urbanized society. In the statistical part of this report students of the cancer problem will find much information useful for comparative purposes.

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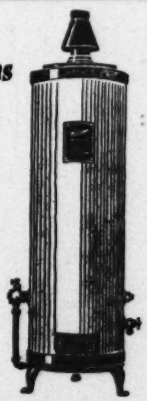

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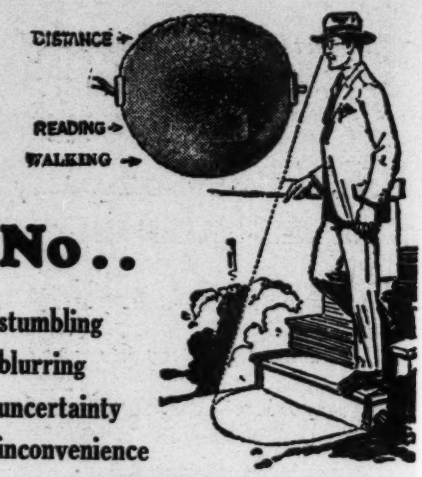

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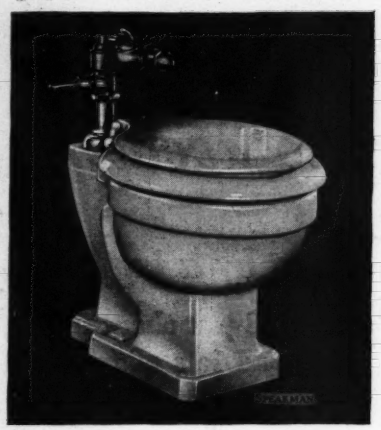

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